State of California – Health and Human Services Agency
Department of Health Services

Preventive Medicine Residency Program
P.O. Box 942732, MS-725, Sacramento, CA 94234-7320

APPLICATION FOR PREVENTIVE MEDICINE RESIDENCY PROGRAM

Please PRINT OR TYPE all responses, then sign and date on the next page. In addition, attach a typewritten Statement of Purpose (see item 22). For items 16-21, if your curriculum vitae (C.V.) contains the requested information, attach your C.V. and write "see attached C.V." in the blank space(s).

1. Name: Last	First	Middle	2. Social Security Number

3. Address (street, city, state, ZIP)	4. Telephone Work: ( ) Home: ( ) Email:

5. Birth date _____ Month Day Year	6. Are you a U.S. citizen? ☐ Yes ☐ No	7. If non-U.S. citizen, specify citizenship and type of visa.	8. Legal Resident of California? ☐ Yes ☐ No

9. Are you licensed to practice medicine in California? (**REQUIREMENT**) ☐ Yes - If Yes: License Number: _____ Expiration: _____ ☐ No	10. In what other states are you licensed? (Include dates)

11. If you are certified by a specialty board: indicate specialty:_____

date of certification:_____ and certificate number:_____

12. Please rate the following possible geographic locations for your residency placement using the following scale: 1 = Preferred, 2 = Acceptable but not preferred.

Southern CA ___ Central Valley ___ S. F. Bay Area ___ Sacramento Area ___ Northern CA ___

13. Applying for: Academic & Practicum ☐ Practicum Year Only ☐	14. If academic year, also applying to: UC Berkeley ☐ UCLA ☐ SDSU ☐	15. Are you applying for a residency stipend? Yes ☐ No ☐

16. EDUCATION, INTERNSHIPS, RESIDENCIES. Have official transcripts of your graduate (post-baccalaureate) education mailed to the program at the address on the next page. Summarize your undergraduate education, graduate education, internships, and residencies here. Attach additional pages or a C.V. if necessary.

Names and Locations of Schools or Institutions Attended	When Matriculated	Major	Diploma or Degree	Date of Completions

17. EXPERIENCE RECORD: List chronologically all experience in medicine, public health, or related fields excluding internship and residencies (but including periods of private practice and military service). The earliest employment should appear first. Attach additional pages or a C.V. if necessary.

Dates		Name and Address (City, State) of Employer	Description of Duties or Position
From	To		

Name: _____

18. Membership in professional or honorary associations:	19. Honors, prizes, awards:

20. Publications:

21. REFERENCES. Request that three persons, including at least two physicians, send a letter of recommendation to the program at the address below. List your references here:

	Name	Occupation and Title	Institution and Telephone
(1)			
(2)			
(3)			

22. STATEMENT OF PURPOSE: Please attach one typed page giving your reasons for wanting to undertake training provided by this preventive medicine residency program. **THE PREVENTIVE MEDICINE RESIDENCY ADVISORY COMMITTEE OF THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES CONSIDERS THIS TO BE A CRUCIAL PART OF YOUR APPLICATION.** Include your future professional plans and any other information that may be helpful to the Committee.

23. Note: An interview is required before a final decision can be made. After your application has been reviewed, we will notify you if you are eligible for an interview.

NOTICE TO APPLICANTS:

The information requested on this form is required by the State Department of Health Services in order to determine your eligibility for acceptance into the Department's Preventive Medicine Residency Program. The information will also be used by the Department's Preventive Medicine Advisory Committee to select candidates for inclusion into the residency training program. Participation in this residency program is voluntary. If you choose to participate, you are required to provide information on these forms. If you do not provide this information, admission into the residency program may be denied.

Any information that you provide may be used by the State Department of Health Services or transferred to the Department of Health Services' Preventive Medicine Advisory Committee and institutions formally participating in the residency training program. Candidates and authorized personnel directly involved in the selection process will be allowed access. If you wish to review these records, contact Kathleen H. Acree, M.D., M.P.H., at the address below. After reviewing your records, you may request in writing that they be corrected or amended to make them accurate, relevant, and complete. Any request for correction or amendment should also be sent to Dr. Acree.

I certify that the information I have provided in my application is correct, and that I have read the above "Notice to Applicants."

_____ _____

Signature **Date**

MAILING ADDRESS: Please mail this application form with attachments to:

Mr. D.L. Gunter, Coordinator
Department of Health Services
Preventive Medicine Residency Program
P.O. Box 942732, MS-725
Sacramento, CA 94234-7320

Please note that the address to the left is for U.S. Mail only For FedEx, UPS, or other courier services, use our street address: 601 North 7th Street, MS-725, ZIP code 95814, and do not indicate the P.O. Box.

In addition, please have official transcripts and letters of recommendation mailed directly to this address. If you have any questions, please telephone (916) 327-6968 or email Dgunter@dhs.ca.gov. Thank you.